

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

518

06280

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: County..... <u>Queen Anne</u> City or town..... <u>Hopewell Centreville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>24 yrs</u> Hospital, institution, or street address where death occurred:..... How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Queen Anne</u> City or town..... <u>Centreville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war..... <input checked="" type="checkbox"/>			
3. (a) FULL NAME <u>Thomas Herbert Everett</u>				3. (b) Social Security Number <input checked="" type="checkbox"/>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>Anne Beale Everett</u>				6. (c) If alive, give age <u>72</u> years			
7. Birth date of deceased (mo., day, yr.) <u>Feb 11 - 1872</u>				8. AGE: Years <u>75</u> Months <u>5</u> Days <u>6</u> If less than one day..... hrs. min.			
9. Birthplace <u>Templeville, D.C. Co - Md</u> (Town, county, and state)				10. Usual occupation <u>Veteran</u>			
11. Industry or business				12. Name <u>Leri Everett</u>			
13. Birthplace <u>Queen Anne Co. Maryland</u>				14. Maiden name <u>Peterson</u>			
15. Birthplace <u>Queen Anne Co. Maryland</u>				16. Informant <u>Mrs Katie Everett</u> Address..... <u>Centreville, Md</u>			
17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof..... <u>July 19 - 47</u> (month) (day) (year) Cemetery or crematory..... <u>Christ Church</u> Location..... <u>Centreville</u> <u>Barton Bros</u>				18. Funeral director Address..... <u>Centreville, Md</u>			
19. (Date rec'd by registrar) <u>July 18 - 47</u>				20. DATE OF DEATH <u>July 17 - 47</u> 9:15 A.M.			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from and that I last saw him/her alive on..... <u>July 17 - 47</u> Immediate cause of death <u>Coronary artery disease</u> DURATION Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death)							
Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....							
23. SIGNATURE <u>H. J. [Signature]</u> M. D. or other..... Address..... <u>Centreville</u> Date signed..... <u>7/18/47</u>							

RECEIVED
JUL 28 1947
BUREAU I.L.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

06281

251

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH:

County Queen Anne
 City or town near - Millington (in Kent CO.)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 1 month
 Hospital, institution, or street address where death occurred:
Melvin Nursing Home
 How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Robert T. Harris

3. (b) Social Security Number

218-09-9036A

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1871 6. (c) If alive, give age _____ years

8. AGE: Years 76 Months 5 Days 20 It less than one day _____ hrs. _____ min.

9. Birthplace Kent Co. Maryland
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Robert T. Harris13. Birthplace Maryland14. Maiden name Annie Winchester15. Birthplace Maryland16. Informant Mrs. John R. Hadaway (sister)Address Chestertown, Md.

17. Burial Date thereof July 26, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chester CemeteryLocation Chestertown, Maryland18. Funeral director J. Willis WellsAddress Chestertown, Maryland

19. July 26, 1947 Registrar Charles Barnes
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947 at 9:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to July 23 1947
 and that I last saw him alive on July 23 1947

Immediate cause of death Cirrhosis DURATION 1 day

Due to Chronic Bright's

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. C. Simpson M. D. or other _____

Address Chestertown Date signed 7-24-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 06282 254

1. PLACE OF DEATH:

County Queen Anne
City or town Queens town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Queen Anne
City or town Queens town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) if veteran, same war

3. (a) FULL NAME

Mary Lillian Hennemon

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Jesse Hennemon

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1875

8. AGE: Years 71 Months 11 Days 4 If less than one day hrs. min.

9. Birthplace Queens town Md
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Louis Morgan rather

13. Birthplace Washington, D.C.

14. Maiden name Deborah Smith

15. Birthplace Stevensville, md

16. Informant Mrs. Edna Gorsuch

Address Baltimore, md

17. Burial Date thereof July 7-1947
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Christfield Cemetery

Location Centerville Md

18. Funeral director John D. Williams

Address Centerville Md

19. July 6- 19 47 Helen M. Adridge
(Date rec'd by registrar) Loc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 47 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to July 1947
and that I last saw her alive on July 4 19 47

Immediate cause of death Hypertension
Cardiovascular Renal Disease
with Cardiac Failure

DURATION

5 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Lane, M.D.

M. D. or other

Address Queens town, md Date signed 7-4-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1947

SECRET

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

06283

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:

County Delaware
 City or town New Castle
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Del. County New Castle
 City or town Wilmington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 518 Walnut St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Arthur Henry

3. (b) Social Security Number

221-05-7409-4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife do not know

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 17 - 19108. AGE: Years 37 Months 11 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Odessa Del.

(Town, county, and state)

10. Usual occupation Laborer11. Industry or business L12. Name Do not know13. Birthplace Do not know14. Maiden name Do not know15. Birthplace Do not know16. Informant Estelle Rinderk neeAddress 518 Walnut St. Wilmington Del.17. Burial Date thereof July 24 - 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory WilmingtonLocation Wilmington Del.18. Funeral director Edgar L. LaneAddress Church Hill Md.19. 7-21- 19 47 Elcie Armstrong

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 47 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death drowning

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 9 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7/20/47Where did injury occur? Chester River (City or town) (County) (State)Injured at home, farm, industry, public place (where?) RiverMeans of injury Boat sunk Injured at work? No23. SIGNATURE W. J. Henry FisherAddress Do not know Date signed 7/20/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 26 1947
BUREAU V.A.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County... Green
 City or town... near Church Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Penn. County... Phila.
 City or town... Phila delphia
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 1832 Spruce St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William W. Parkin

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) August 15-1911 6. (c) If alive, give age _____ years
 8. AGE: Years 35 Months 10 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Pennsylvania
 (Town, county, and state)
 10. Usual occupation Merchant
 11. Industry or business Store
 12. Name Ezekial Parkin
 13. Birthplace Penna.
 14. Maiden name Millie Whitaker
 15. Birthplace Penna.

16. Informant Mr. Edward Hickman
 Address Roberts, Ind.
 17. Burial Date thereof July 10-1947
 (Burial, cremation, or removal) (Which?) (month) (day) (year)
 Cemetery or crematory Mount Zion
 Location Philadelphia Pa.
 18. Funeral director Edgar H. Lane
 Address Church Hill Ind.

19. July 7 1947 Edgar H. Lane
 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947 at 6 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 @ 5 AM 1947 to July 7 @ 6 AM 1947
 and that I last saw him alive on July 7 1947

Immediate cause of death pulmonary edema
 Due to acute anterior and posterior myocardial infarctions
 Due to coronary thrombosis, acute
 Other conditions none

(Include pregnancy within 8 months of death)
 Major findings of operations none
 Date of op. _____
 Autopsy results not done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE A. R. Coppola, M.D.
 Address Christstown, Md. Date signed July 7, 1947
 M. D. or other

RECEIVED
BUREAU OF HEALTH
STATE DEPARTMENT OF HEALTH

RECEIVED
JUL 9 1947
BUREAU OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

6285 251

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Queen AnneCity or town..... Church Hill
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 3 months

Hospital, institution, or street address where death occurred:

Main St Church Hill Md

How long in hospital or institution?.....

3. (a) FULL NAME

Jane Rochester Richards

3. (b) Social Security Number

4. Sex.....

5. Color of race..... white6. (a) Single, married, widowed, or divorced..... widowed6. (b) Name of husband or wife..... Thomas Richards6. (c) If alive, give age..... 18 years7. Birth date of deceased (mo., day, yr.)..... Feb 15, 18878. AGE: Years..... 60 Months..... 5 Days..... 3 If less than one day..... hrs. min.9. Birthplace..... Queen Anne Count
(Town, county, and state)10. Usual occupation..... Homemaker11. Industry or business..... Own home12. Name..... John McClary Rochester13. Birthplace..... Queen Anne Count14. Maiden name..... Ella Meredith15. Birthplace..... Queen Anne Count16. Informant..... Miss Ella RochesterAddress..... Church Hill, Md17. Burial Date thereof..... July 21, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Church Hill CemLocation..... Church Hill Ind.18. Funeral director..... Edgar L. LaneAddress..... Church Hill Ind.19. July 21 1947 Edgar L. Lane
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md County.....City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)Street No..... 2632 Maryland Ave
(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 18 1947 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 13 1947 to July 18 1947and that I last saw her alive on July 18, 1947 1947Immediate cause of death..... coronary thrombosisDue to..... coronary atherosclerosisDue to..... 2 years

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

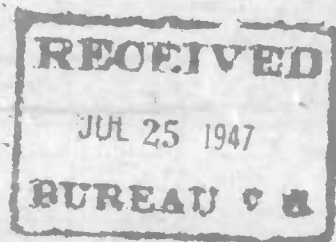
Accident, suicide, or homicide..... Date of

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Charles L. Lane M.D. or otherAddress..... Church Hill Ind Date signed 7-24-47



1887-2-15-

60-2-3

1947-7-18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County..... *g.a.*
 City or town..... *Rural Centerville*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Ind.* County..... *g.a.*
 City or town..... *Rural Centerville*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Amanda Scott

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

James Scott

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

Unknown

8. AGE:

Years

Months

Days

If less than one day

Approx. 90 hrs. min.

9. Birthplace

Caroline Co. Ind.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

James Montgomery

13. Birthplace

Ind.

14. Maiden name

Unknown

15. Birthplace

Ind.

16. Informant

Army Scott

Address

Centerville Ind.

17.

(Burial, cremation, or removal. Which?)

Date thereof

2-13-47

Cemetery or crematory

Cardora

Location

Cardora Ind.

18. Funeral director

Edgar S. Lane

Address

Church Hill Ind.

19.

(Date rec'd by registrar)

19

Edgard S. Lane

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 10 1947 at 3:30 PM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1947 to July 10 1947
 and that I last saw him alive on..... 19.....

Immediate cause of death

Cardiac arrest

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Edgard S. Lane

M. D. or other

Address.....

Date signed

7/14/47

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

RECEIVED
JUL 25 1947
BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date is shown on

FILM NO. G 111 AUG 6-1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

pc 06287
Reg. Dist. No. 252

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Queen Anne's
City or town Centersville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2101 E EAGER ST
(If rural, give LOCATION)

2(a) If veteran, name war no ✓

3. (a) FULL NAME

John Seidler

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Vergie German

7. Birth date of deceased (mo., day, yr.) July April 23, 1900 6. (c) If alive, give age 44 years

8. AGE: Years 47 Months Days If less than one day hrs. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name Joseph Seidler

13. Birthplace Baltimore Md (Wagoner)

14. Maiden name Annie Edgemoor

15. Birthplace Baltimore, Md

16. Informant Henry Seidler

Address 2101 E. Eager St. Md

11. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 30, 47
(month) (day) (year)

Cemetery or crematorium Centersville

Location Centersville Maryland

18. Funeral director Barton Bros

Address Centersville, Maryland

19. 7-30-19-47 Elmer Armstrong Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 19 47 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19

Immediate cause of death Drowning

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of

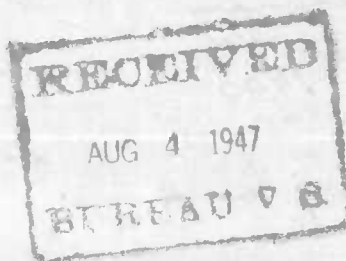
Where did injury occur? Mr. Stevensville Queen Anne's Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Apparently went to dock & fell overboard. Injured at work?

23. SIGNATURE W. Henry Fisher M. D. or other

Address Centersville Md Date signed 7/30/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 253

06288

96

1. PLACE OF DEATH:

County Queen Anne

City or town Chester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne

City or town Chester
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas Howard Thompson

3. (b) Social Security Number

220-03-6144

4. Sex M 5. Color or race W 6.(a) Single, married, widowed or divorced Married

6.(b) Name of husband or wife Mary Madeline Thompson

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) May 14, 1913

8. AGE: Years 34 Months 2 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Chester, Queen Anne, Maryland
(Town, county, and state)

10. Usual occupation Water man

11. Industry or business

12. Name Thomas Howard Thompson

13. Birthplace Chester Maryland

14. Maiden name Mary Elizabeth Thomas

15. Birthplace Chester, Maryland

16. Informant Mary Madeline Thompson

Address Chester, Md.

17. Burial Date thereof July 29-47
(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Stevensville

Location Stevensville Maryland

18. Funeral director Barton Bros

Address Centerville Maryland

19. 7-28 47 Elizabeth Hosten
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947 at 6:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to July 1947

and that I last saw him alive on July 26 1947

Immediate cause of death Aortic Aneurysm DURATION 13 mos.

Due to Not due to syphilis
(8/27/47-9-5)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William C. James MD
M. D. or other _____

Address Queenstown Md Date signed 7-26-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

6497
213

1. PLACE OF DEATH:

County Duane AnneCity or town and Grasonville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? few days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Duane AnneCity or town Grasonville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war no

3. (a) FULL NAME

James Arthur Williams

3. (b) Social Security Number

none4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Laurie Johnson7. Birth date of deceased (mo., day, yr.) May 13 - 19058. AGE: Years 42 Months ? Days ? If less than one day _____ hrs. _____ min.9. Birthplace Grasonville Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Day laborer12. Name Richard Williams13. Birthplace Grasonville Maryland14. Maiden name Bessie Williams15. Birthplace Grasonville Maryland16. Informant Percy WilliamsAddress Grasonville Maryland17. Burial Date thereof Nov - 19 - 47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GrasonvilleLocation Grasonville Maryland18. Funeral director Barton BrosAddress Centerville Maryland19. Nov 20 1947 Elizabeth Daptis

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

Missing since 3 July 1947 at _____ M

20. DATE OF DEATH _____

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death His bones were found in a field on farm near Hiteparks MdDue to He has been missing since July 12 - 1947 - He was identifiedDue to from clothing found at spot by his brotherOther conditions Death was probably due to exposure & malnutrition

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Henry FisherDeputy Mgr. Express Co. M. D. or other _____Address Centerville Md Date signed 11/18-47

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NOV 29 1947
H. H. H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 062843 253

1. PLACE OF DEATH:

County Queen Anne

City or town Chester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne

City or town Chester
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Blanche Olevia Wright

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Rayfield Wright

6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) February 28 1900

8. AGE: Years 47 Months 5 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Randolph Thompson

13. Birthplace St Marys Co. Va.

14. Maiden name Isabelle Vester Thompson

15. Birthplace Mekens Co. Va.

16. Informant Rayfield Wright

Address Wheat Md.

17. Burial Date thereof 7-19-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Catholic

Location Baltimore City

18. Funeral director Leon S. Henry

Address Easton Md.

19. July 17 19 47 Elizabeth Hoxter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 19 47 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 14 19 47 to July 15 19 47

and that I last saw him alive on July 15 19 47

Immediate cause of death Cerebral Hemorrhage

DURATION

Due to Hypertensive Cardiovascular Disease

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William C. Henry, MD.

M. D. or other _____

Address Queen Anne, Md. Date signed 7-15-47

MARGIN RESERVED FOR BINDING

VS A15

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